2018 Update On The Child Fatality And Near Fatality External Review Panel

Program Review and Investigations Committee

July 12, 2019

Panel Overview

- By statute, the panel conducts comprehensive reviews of child fatalities and near fatalities that are reported to the Cabinet for Health and Family Services.
- Members: 15 voting, 5 nonvoting
- Panel is independent but attached to the Justice & Public Safety Cabinet.
- Reviewed 134 Cases from FY 2017:
  - 51 fatalities
  - 83 near fatalities

This Report's Focus

- Panel compliance with governing statutes
- National data on child fatalities
- Data issues in reporting and receiving cases
- Panel's recommendations from 2014 to 2018

Statutory Compliance

- The panel is compliant regarding
  - Membership
  - Meeting Schedule
  - Meeting Attendance
  - Posting Updates
  - Summary Reports
  - Destruction of Records

Statutory Compliance

- The panel is not in compliance with the December 1 deadline for its annual report, which was published February 1.
- Delays in receiving cases for review
  - DCBS' internal review process takes an average of 10 months
  - 4 to 5 months for case to be uploaded to electronic data site

Recommendation 1

The General Assembly may wish to change the due date of the panel's annual report to February 1 to provide the panel with enough time to receive and review all cases of the previous fiscal year.

Recommendation 2

The panel should establish a policy for the destruction of electronic documents.

Referral Of Cases

- Local child fatality teams may refer cases to the panel.
  - If there are issues with the local review process, cases could be missed and not forwarded to the panel.

Referral Of Cases: Jurisdictional Issues

- Example:
  - Differing views on which county should claim the child's death.

Referral Of Cases In Other States: Reporting Requirements

- Nationally, child fatalities arising from maltreatment may be underreported by 58 to 76%.

Referral Of Cases In Other States: Reporting Requirements

- Some states mandate that specified state and local entities report child fatalities to the state's review panel. Examples:
  - Alaska medical examiner's office,
  - Georgia coroners' offices, and
  - Michigan local child fatality review teams.

Referral Of Cases In Other States: Reporting Requirements

- Some states allow the panel to call upon state agencies to assist in reporting child fatalities and providing additional data. Examples:
  - California Vital Statistics;
  - Georgia law enforcement;
  - North Carolina hospitals; and
  - Texas emergency management services, firefighters, chief juvenile probation officers, and child educators.

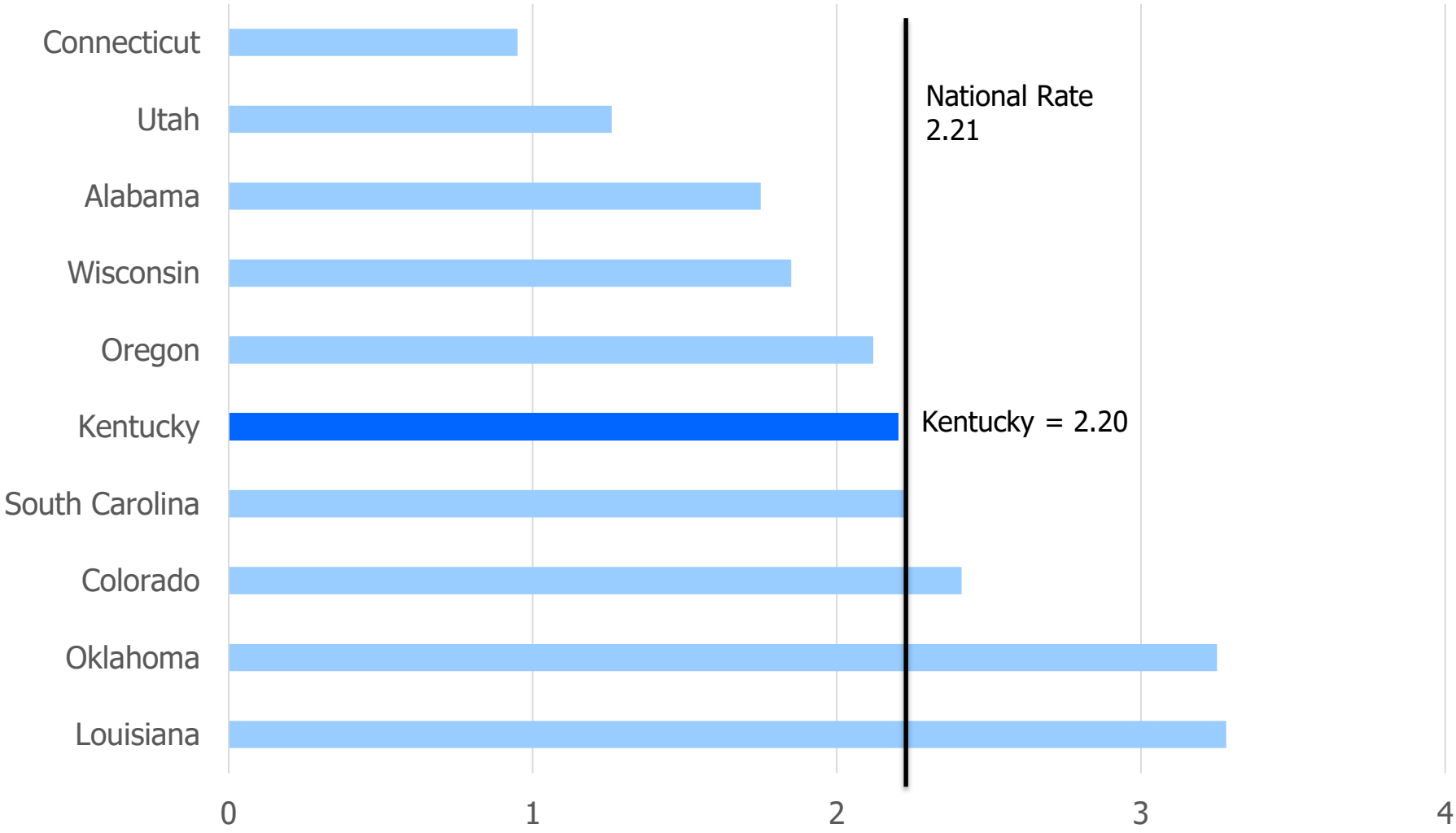
Referral Of Cases: SUDI

- 9 of 10 Sudden Unexplained Death of Infants (SUDI) in Kentucky include unsafe sleep conditions as a contributing factor.
  - Unsafe sleep conditions are often analyzed by the panel.

Referral Of Cases: SUDI

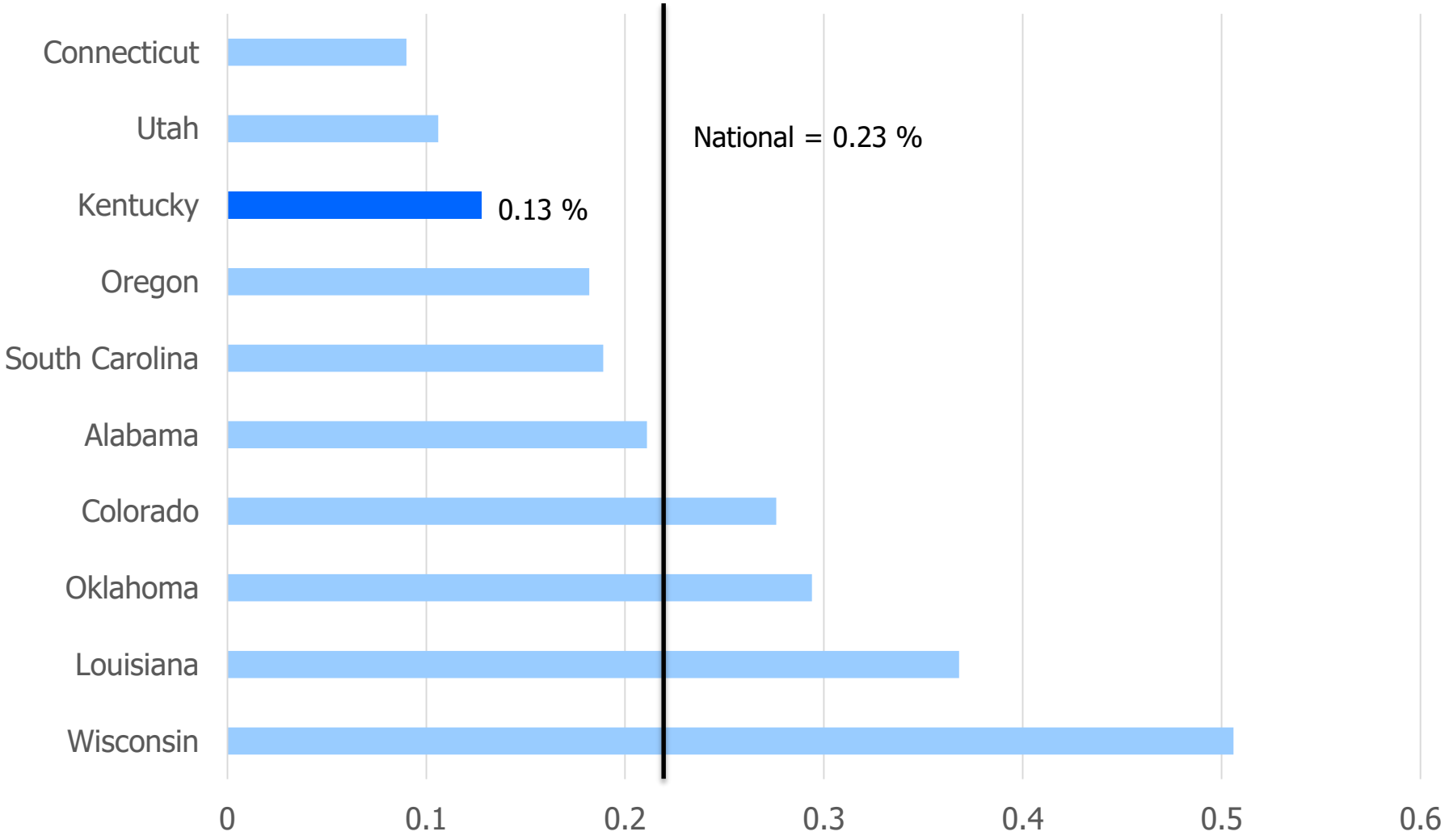
- There are discrepancies between the number of SUDI cases the panel reviews each year and the number reported through the Department for Public Health.
  - In 2015:
    - 88 SUDI deaths in the state, panel only reviewed 10.

Fatalities Per 100,000 Children, 2008 - 2017



Source: Compiled by Program Review Staff from United States. Dept. of Health and Human Services. Children's Bureau. *Child Maltreatment,* 2008 to 2017.

% Of Reports Of Child Abuse And Neglect Involving A Fatality, 2008 - 2017



Source: Complied by Program Review staff from United States. Dept. of Health and Human Services. Children's Bureau. *Child Maltreatment*, 2008 to 2017.

Fatality And Near Fatality Panels In Kentucky And Selected States

Entity	Abuse And Neglect Cases Only	Reviews Near Fatalities	Coordinates With Local Teams
Kentucky Child Fatality And Near Fatality External Review Panel	√	√	
Kentucky State Child Fatality Review Team (DPH)			√
Colorado Child Fatality Review Team	√	√	
Colorado State Child Fatality Prevention Review Team			√
Massachusetts Child Fatality State Review Team		√	√
New Jersey Child Fatality And Near Fatality Board	√	√	
Oklahoma Child Death Review Board		√	√
Tennessee State Child Fatality Review Team			√

Panel Recommendation Categories

1. DCBS (13 panel recommendations)
2. Substance Abuse (8)
3. Courts (5)
4. Medical Providers (8)
5. Law Enforcement (9)
6. Coroners (3)
7. General (9)

1. DCBS

- DCBS is in transition
  - Implementing state and federal legislation.
  - Transitioning to Culture of Safety model.

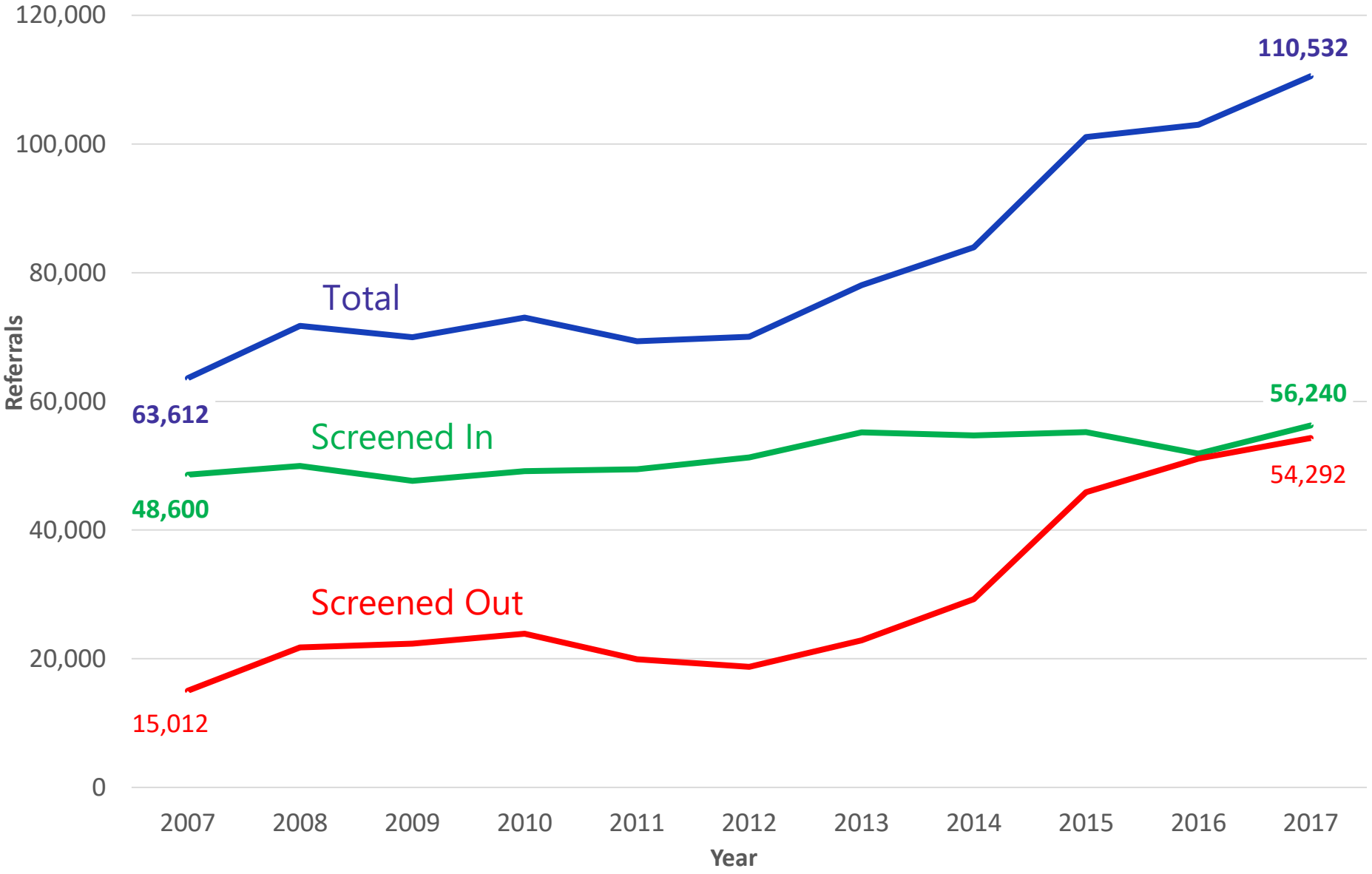
1. DCBS: Screening Out

- The panel recommended DCBS review its protocols for screening out, which is when referrals made to DCBS do not meet its acceptance criteria for further investigation.

1. DCBS: Screening Out

- The panel recommends increased review when a referral
  - Involves children under the age of 4
  - Is a repeat referral
  - Is made by a professional serving the child.
- 27 panel cases from FY 2017 were screened out
  - 10 fatalities, 17 near fatalities

Referrals To DCBS, 2007 to 2017



Source: Compiled by Program Review Staff from United States. Dept. of Health and Human Services. Children's Bureau. *Child Maltreatment*, 2007 to 2017.

1. DCBS: Screening Out

- DCBS' position is that the number of calls screened out should be increased.
- DCBS proposal: a full differential response system that would enable DCBS to provide different services based on the assessed level of risk.

2. Substance Abuse

- In 2017, substance abuse was a factor in 45% of all DCBS cases.
- Substance abuse by a caregiver was a factor in 46% of cases reviewed by the panel for FY 2017.
  - 30 fatalities
  - 32 near fatalities

2. Substance Abuse: Neonatal Abstinence Syndrome

- Neonatal Abstinence Syndrome, NAS, is when an infant, prenatally exposed to drugs, exhibits signs and symptoms of withdrawal following birth.
- Half of all opioid-exposed babies are diagnosed with NAS.

2. Substance Abuse: Neonatal Abstinence Syndrome

- The panel recommends increased resources for the Department for Public Health to provide wraparound services and resources for affected infants and families.

2. Substance Abuse: Medication Assisted Treatment

- Medication-Assisted Treatment (MAT) combines medication with behavioral therapy and counseling to combat substance abuse.
- Panel recommends:
  - Ensuring that all required treatment components are provided.
  - Mandated training on the dangers present for children in the home.

2. Substance Abuse: Family Drug Courts

- The Jefferson Family Recovery Center includes:
  - Regular appearances before the judge
  - Substance abuse treatment
  - Counseling services
  - Drug testing
  - Parenting classes
- May 2019: 25 clients enrolled. 7 have already completed the substance abuse treatment component.

3. Medical Providers

- The panel regularly recommends that medical providers provide education to new parents on abusive head trauma and safe sleep practices.

4. Courts

- The panel recommends open court proceedings for dependency, neglect, and abuse proceedings.
- Kentucky's Open Court Pilot Project began in 2018.

5. Law Enforcement

- The panel recommends:
  - Training for law enforcement on how to approach child death scenes
  - Drug testing of caregivers as a best practice

6. Coroners

- Notifications of child deaths to appropriate agencies have increased.
- Use of the Sudden Unexplained Infant Death form is increasing but the form is often incomplete.
- Local fatality review teams are increasing in number.

7. General

- KRS 311.601 requires pediatricians and other medical providers to receive education on pediatric abusive head trauma.
- KRS 156.095(8) mandates that the Kentucky Department for Education provide comprehensive training for employees on child abuse and neglect. The training is to be completed every two years.
- KRS 199.466 allows a parent or legal guardian to request a background check on an individual caring for their child.

Recommendation 3

Recommendations in the panel's annual reports should be easily identifiable and clearly stated.

State	Average Number Of Reports
Alabama	9,165
Colorado	10,734
Connecticut	8,502
Kentucky	18,094
Louisiana	10,140
Oklahoma	10,998
Oregon	10,549*
South Carolina	13,123
Utah	10,623
Wisconsin	4,776

*Oregon reported for period between 2012 to 2017.
Source: Compiled by Program Review Staff from United States. Dept. of Health and Human Services. Children's Bureau. *Child Maltreatment*, 2008 to 2017.